SAMHSA ADVISORY
Substance Abuse and Mental Health Services Administration

MANAGING CHRONIC PAIN IN ADULTS WITH OR IN RECOVERY FROM SUBSTANCE USE DISORDERS

Chronic noncancer pain (CNCP) is a common condition in the United States. CNCP is commonly defined as pain that is (1) unassociated with an imminently terminal condition; (2) unlikely to subside after tissue heals, therefore requiring long-term management; and (3) not caused by identifiable tissue pathology (e.g., fibromyalgia). Current statistics show that approximately 20 percent of U.S. adults experience chronic pain that lasts more than 6 months (Dahlhamer et al., 2018).

Chronic pain and substance use disorder (SUD) have comparable physical, social, emotional, and economic effects on health and well-being. Both conditions also have many shared neurophysiologic patterns (Chang & Compton, 2013). As a result, treatment for one condition can support or conflict with treatment for the other. Specifically, medication that may be appropriate to treat CNCP may not be appropriate for patients with an SUD history. Additionally, misuse of medication for pain may contribute to addiction or threaten recovery, while unrelieved pain can be a trigger for substance use. Effective CNCP management in patients with or in recovery from SUDs must acknowledge and treat both conditions simultaneously.

This *Advisory*, based on the Substance Abuse and Mental Health Services Administration's (SAMHSA) Treatment Improvement Protocol (TIP) 54, *Managing Chronic Pain in Adults With or in Recovery From Substance Use Disorders*, is for primary care providers who treat or are likely to treat adult patients with or in recovery from SUDs who present with chronic pain. It addresses screening and assessment tools, nonpharmacologic and nonopioid treatment for chronic pain, and the role of opioid therapy in people with CNCP and SUDs.

Key Messages

- Screening and assessment for all SUDs should be a routine part of all pain assessment.
- Pain management should maximize nonpharmacologic therapies and nonopioid pharmacotherapies before any controlled substance is prescribed.
- Patient education is necessary for informed consent and shared decision making, and equips patients to take an active role in their treatment.
- Patients may jeopardize their functioning and recovery by undertaking pain treatment with opioids; therefore, communication and education are critical for success.

Screening and Assessment To Support Pain Management in the Context of SUDs and Recovery

Chronic pain is a multifaceted condition requiring thorough screening and assessment that go beyond measuring pain intensity. In addition to speaking with the patient, providers need to obtain the patient's consent to communicate with family members, pharmacists, and other health professionals to ensure a comprehensive understanding of the patient's pain, mental and emotional conditions, and substance use status.

Key elements of a comprehensive assessment are:

- A physical exam.
- Pain and coping mechanisms.
- Family concerns.
- Functioning related to pain and SUD (if indicated).
- Mental status.
- Co-occurring conditions and disorders, including psychological conditions, medical conditions, and cognitive impairments.
- Substance use history and risk for addiction:
  - Family history of SUDs
  - Medication-assisted treatment history, per SAMHSA's revised 42 CFR Part 2 (which protects patient records created by federally assisted programs for SUD treatment and facilitates coordination of care)
  - Other clinician notes and/or medical records
  - Prescription monitoring program data (if available) regarding current or prior SUDs or treatment

Commonly Used Screening Tools for Pain, SUDs, and Co-Occurring Conditions

- Pain, Enjoyment of Life and General Activity (PEG) scale for pain assessment
- National Institute on Drug Abuse Quick Screen for substance use. Follow positive responses with "Have you ever had a problem with alcohol or drugs?"
- Alcohol Use Disorders Identification Test (AUDIT)
- Opioid Risk Tool (ORT)
- A Brief Measure for Assessing Generalized Anxiety Disorder (GAD-7)
- Patient Health Questionnaire-4 (PHQ-4)
- Patient Health Questionnaire-9 (PHQ-9)*

* To score the PHQ-9, add the numbers that correspond to each response. Total scores range from 0 to 27 (0–4: None-minimal depression; 5–9: Mild depression; 10–14: Moderate depression; 15–19: Moderately severe depression; 20–27: Severe depression). In addition to the total score, review responses to Question #9 (suicidality) and the unnumbered question below it (the effect of symptoms on the patient's daily functioning) when determining whether to initiate or refer for further assessment and treatment (Kroenke & Spitzer, 2002; Kroenke et al., 2001; Richardson et al., 2010).

When assessing for SUDs, providers should have an open and honest conversation with patients about their substance use history and the risk of cross-addiction. Providers should screen for all substances, not just opioids, because certain substances can be contraindicated with prescribed medicines or can affect medication tolerance. Substances that should be screened for can include alcohol, caffeine, nicotine, and licit and illicit drugs with abuse potential, such as cannabis, depressants, hallucinogens, opioids, and stimulants.

Screening and assessment should be done at the beginning of treatment as well as at regular intervals, because several factors may alter the course of treatment:

- Opioid tolerance
- Patient adherence to the recommended treatment plan
- Improvement or deterioration in the patient's underlying disease condition and function
- Change in the patient's pain threshold
- Changes in cognitive function and mental health

Managing Chronic Pain: An Overview

Chronic pain is a challenge for providers and patients alike. It is not always possible to eliminate pain completely for any substantial amount of time. When pain cannot be completely eliminated, providers and patients should set reasonable expectations and discuss treatment goals that center around reducing pain and improving function and overall quality of life.

When creating a management plan, a provider should identify two key factors: which category of pain the patient is experiencing, and if the patient is in recovery from an SUD or is actively using substances.

There are three key categories of pain: nociceptive, neuropathic, and mixed nociceptive/neuropathic (Colloca et al., 2017). Nociceptive pain results from stimulation of the nociceptors, neural receptors in the skin and spinal cord that detect potentially harmful situations, such as touching a hot stove. In addition to thermal triggers, nociceptors respond to chemical or mechanical stimulation.

Neuropathic pain is caused by damage or disease affecting the sensory nervous system. This can include compression, injury, infection, autoimmune condition, and vascular or metabolic disease. Neuropathic pain often manifests as burning or coldness, numbness, itching, or a "pins and needles" feeling at the site of pain.

Once a provider identifies the patient's pain category, he or she should determine if the patient is either actively using substances or in recovery. If the patient is actively using substances, the first step is to refer the patient to an addiction treatment specialist. Next, the provider should try to identify nonopioid, and possibly nonpharmacologic, therapies to relieve pain.

If the patient is in recovery, determine if he or she is taking medication for an SUD. If not, assess pain levels and implement nonopioid treatments and nonpharmacologic therapies. If pain does not abate, consider an opioid treatment trial, if appropriate, and closely monitor the patient.

If the patient is using agonist therapy (i.e., methadone or buprenorphine), continue the medication with the addition of nonpharmacologic treatments and/or nonopioid pharmacotherapies. If pain persists, the provider should consider dividing the current dose, increasing the dosage, or both. Addition of an opioid analgesic may be considered. This is most safely done in a hospital environment, where the patient can be monitored for signs of opioid toxicity.

Treatment is best managed with the help of a team. Depending on the patient's SUD status, the team may include any or all of the following: primary care provider, addiction specialist, pain clinician, pharmacist, psychiatrist/psychologist, physical or occupational therapist, and/or family and friends (with patient consent).

Nonpharmacologic treatments

Nonpharmacologic treatments have evidence-based support for their effectiveness in treating CNCP (Zhang et al., 2019). The most commonly accepted treatments include therapeutic exercise, physical therapy (PT), cognitive–behavioral therapy (CBT), and complementary and alternative medicine (CAM).

PT is a well-known nonpharmacologic treatment for chronic pain. Physical therapists use a variety of hands-on approaches to help patients increase their range of motion, strength, and functions. Research indicates that PT is effective in easing pain caused by numerous physical conditions (Courtney et al., 2017; Saper et al., 2017). Therapeutic exercise can increase strength, aerobic capacity, balance, and flexibility; improve posture; and enhance general well-being (CADTH Rapid Response Reports, 2016; Saper et al., 2017; Thompson et al., 2016). Evidence shows that it can help alleviate low back pain, neck pain, fibromyalgia, and other conditions. It has also been shown to reduce anxiety and depression.

CBT helps patients with CNCP reduce pain and associated distress, disability, depression, and anxiety. CBT is particularly effective in easing pain associated with lumbar spine surgery, low back pain, spinal pain, and chronic neck pain (Archer et al., 2016; Hajihasani et al., 2019; Malfliet et al., 2019; Thompson et al., 2016).

CAM encompasses multiple health systems, practices, and products that are not typically considered part of conventional medicine. These include acupuncture, chiropractic, and massage therapy. Acupuncture has been extensively studied for back and neck pain, migraines, and osteoarthritis/knee pain (National Center for Complementary and Integrative Health, 2020). Chiropractic treatments are most commonly associated with neck and back pain. Similarly, massage appears to be effective in reducing pain and improving function and quality of life in patients with chronic neck pain (Furlan et al., 2015; Saha et al., 2017).

Nonopioid pharmacologic therapies

A treatment plan based on pain type, SUD status, and optimal treatment team members will likely include nonopioid pharmacologic therapies. These medications are not addictive and include anti-inflammatories, adjuvant medications, and topical analgesics.

Anti-inflammatories. The primary anti-inflammatories include acetaminophen and nonsteroidal anti-inflammatory drugs (NSAIDs). Acetaminophen use should not exceed 4 grams per day and, due to potential adverse effects on the liver, patients with hepatic disease should not exceed 2 grams per day. NSAIDs work particularly well at easing musculoskeletal, dental, lower back, and inflammation-based pain. However, NSAIDs can have several side effects, including increased risk for gastrointestinal ulcers, renal toxicity, and cardiovascular effects, including stroke and heart attack (Derry et al., 2016; Himstreet et al., 2017).

Adjuvant medications. Adjuvant medications (medications originally developed for other conditions that have been found to have analgesic properties) primarily consist of antidepressants and anticonvulsants. Antidepressants found to have analgesic effects include:

- **Serotonin–norepinephrine reuptake inhibitors**—Most effective in relieving "nonstructural" pain such as migraines, fibromyalgia, and low back pain
- **Tricyclic antidepressants**—Particularly effective for neuropathic pain, fibromyalgia, migraine, and functional bowel disorders

- **Antipsychotics**—Effective primarily for migraine and cluster headaches

Anticonvulsants have shown efficacy in relieving fibromyalgia, migraines, and neuropathic pain. While some muscle relaxants have an analgesic effect during an acute pain episode, many have significant abuse potential. Additionally, some muscle relaxants may increase the effects of opioids and are therefore not recommended.

Some adjuvant medications—namely antidepressants and antipsychotics—are psychotropic in nature and may affect behavior, mood, thoughts, and/or perceptions. They can also increase the risk of serotonin syndrome, a condition that can cause agitation, confusion, fever, seizures, and even death, if undetected and untreated. Additionally, some of these medications are known to have abuse potential and should be monitored by the prescriber (do Nascimento et al., 2020).

Topical analgesics. Topical analgesics (lidocaine, methyl salicylate, and capsaicin) have been shown to ease pain. Because they work locally, they have very few systemic side effects.

Prescribing Opioids for Pain Management and Addiction Treatment

Providers should adopt a universal precautions approach when treating patients with CNCP. In the context of pain management, this means providers should prescribe nonpharmacologic and/or nonopioid therapies before considering opioid use. If pain levels necessitate opioid use, providers should evaluate the patient's SUD history and risk of relapse (Dowell et al., 2016). Note that a history of SUDs does not always preclude the use of opioids to treat CNCP.

For patients with no history of SUDs or patients in recovery from SUDs, providers should establish clear treatment goals and guidelines that include (Centers for Disease Control and Prevention, 2020):

- Shared goals, known risks, and expected outcomes of the therapy.
- Establishing a treatment agreement, including an opioid agreement if applicable.
- Assessment of pain level and function.
- Schedule of follow-up visits and reassessments.

For patients who are currently in treatment for SUDs, including taking medication for opioid use disorder (OUD), providers need to work closely with SUD treatment providers to monitor treatment outcomes of both SUD and CNCP for both benefit and harm. In many cases, control of CNCP may include dose escalation of OUD medications.

For patients with active untreated addiction, it may be impossible for providers in the primary care setting to provide the comprehensive services necessary to treat both conditions. In this case, primary care physicians should refer patients with active SUDs to a treatment center and a pain specialist, and work closely with both providers (Dowell et al., 2016).

If the patient refuses treatment, providers should use motivational interviewing techniques. If the patient still refuses, then the patient should not be prescribed opioids for CNCP in the primary care setting. In some instances, patients with active OUD may be treated with OUD medications for pain management (Dowell et al., 2016).

OUD medications for chronic pain management

For patients who are in SUD treatment and currently taking OUD medication, providers may consider increasing the medication dosage to manage both OUD and chronic pain. The schedule and dosage of opioid agonists needed to support withdrawal from opioids and reduce cravings may be insufficient to relieve pain in patients with CNCP. A higher-than-usual dose of OUD medication may be required to treat chronic pain.

Methadone. Patients prescribed methadone for OUD ideally should have their pain care coordinated by both a pain specialist and an SUD treatment provider. Although methadone's ability to manage craving and withdrawal symptoms can last up to 36 hours, its analgesic properties generally last for 6 to 8 hours. Given this disparity and methadone's long half-life, extra caution, monitoring, and patient education are needed. If additional opioids are required, short-acting, full-agonist opioids should be added to the patient's treatment regimen (American Society of Addiction Medicine [ASAM], 2020).

Pain patients may take 10 days or more to stabilize on methadone, which means the provider must adjust the medication slowly and balance sufficient dosing with risk of overdosing. Risks with methadone include accumulation concerns, drug interaction, and QT prolongation, an EKG finding that indicates the heart is taking longer than normal to recharge between heartbeats. Primary care providers should work closely with treatment professionals to monitor these potential issues.

Buprenorphine. Buprenorphine is an effective analgesic for some individuals and can benefit patients who have both SUDs and chronic pain. Its analgesic effects last 6 to 8 hours. Buprenorphine should be given three to four times a day when used primarily for pain reduction (ASAM, 2020).

Naltrexone

Naltrexone is a long-acting oral or injectable medicine that blocks the effects of opioids. It is also used to reduce alcohol consumption. It is not meant for managing pain and is not a viable option for patients currently prescribed opioids (National Library of Medicine, 2020).

Opioid use for pain management

For patients with a history of SUDs, opioids may be considered if their use is carefully managed. Management includes selecting the appropriate opioid, dosage titration, treatment agreements, and testing and monitoring.

Opioid options. When choosing the appropriate opioid for a patient, providers should select a medication that is safe and will effectively relieve pain without increasing the risk of relapse. Choosing the correct opioid dose for patients with SUDs can be challenging, particularly for patients with a history of opioid use or opioid addiction.

Dosage titration. A general guide for adjusting medications is to start with a low dose of opioid to ease pain, then titrate as needed to maintain pain relief without decreasing function or risking addiction or relapse. When an effective dose has been determined, total opioid dose should be increased slowly, only if needed, as tolerance develops.

When monitoring for dosage, providers need to be aware of both tolerance and hyperalgesia concerns. Tolerance can occur regardless of opioid type, dosage, type of administration, and dosage schedule. When patients develop tolerance to the analgesic effects of a particular opioid, providers can consider either escalating the dosage or using opioid rotation (switching from one opioid to another).

Hyperalgesia, or oversensitivity to pain, can occur in some patients using opioids for chronic pain. Increasing doses of opioids can exacerbate pain rather than relieve it, resulting in opioid-induced hyperalgesia (OIH).

A provider working with a patient who develops OIH should implement a multimodal approach, using a combination of nonpharmacologic and nonopioid treatments to help reduce the need for opioids.

Before initiating opioid treatment, providers should determine whether their patients have access to a naloxone kit and prescribe one if they do not. This should be done for patients receiving opioids for either chronic pain or OUD. Current federal guidance also suggests discussing naloxone with patients at risk of opioid overdose, even if they are not prescribed opioids (Food and Drug Administration, 2020).

Treatment agreements. Treatment agreements are mutually agreed-on plans between the provider and the patient. The agreement outlines the course of action for treatment, including nonpharmacologic treatments, nonopioid therapies, and opioid medication, if indicated.

The patient should be included in the planning and writing of the treatment agreement. This not only provides clear expectations for the patient and provider, but also preserves patient autonomy and establishes the necessary guidelines for successful treatment. A treatment agreement protects a patient's access to scheduled medications while also protecting the provider's license to prescribe those medications.

Providers can find a sample pain treatment agreement in SAMHSA's TIP 54, Exhibit 5-6, on page 73.

Testing and monitoring. Testing and monitoring are recommended for patients taking opioids for chronic pain. Patients on opioid therapy should typically meet with a provider at least once a month (Dowell et al., 2016). However, patients with a history of SUDs may require more frequent visits. A schedule of routine visits not only helps patients see their pain as a manageable condition, but also allows the provider to closely monitor adherence. During these visits, providers should assess pain level, monitor pill counts, note any signs of addiction or relapse, and identify unusual, drug-related behavior.

Urine testing is the most common way to detect prescribed and unprescribed substances, as well as verify adherence to the medication plan. Common types of urine drug tests include immunoassay screens and tests that identify specific substances using gas chromatography/mass spectroscopy or high-performance liquid chromatography.

Any unexpected result should be discussed in person with the patient. If the patient has repeated unexpected results, it would be prudent to have the patient evaluated by an addiction treatment specialist.

Tapering and discontinuing opioid therapy

When pain has been resolved, a provider should gradually discontinue opioid therapy. Other reasons to stop opioid treatment for chronic pain include:

- Opioids are no longer effective.
- Adverse effects are unmanageable.
- The patient does not adhere to the treatment agreement.
- The patient is misusing or diverting the medication.

The reason for discontinuing opioid therapy will determine the plan for tapering off the medication. If the reason is due to nonadherence to the treatment agreement or misuse of opioids, the provider should refer the patient for addiction treatment.

In all other cases, providers should work with patients to taper off their medications in a controlled office setting. As providers explain the tapering process, they should assure patients that their opioid therapy is being discontinued, not their pain management care.

It is also important for providers to explain that tapering is not the same as detoxification. Tapering refers to the slow decrease in the amount of the prescribed opioid. Detoxification is the medical management of acute withdrawal from the medication. With tapering, there may be some withdrawal symptoms, such as gastrointestinal distress, bone or muscle pain, anxiety, insomnia, and/or increased pain sensitivity at the original pain site. However, a patient should not experience severe withdrawal.

Patients should also be informed of the risks of rapid opioid tapering (U.S. Department of Health and Human Services Working Group, 2019). These include significant opioid withdrawal, exacerbation of pain, psychological distress, and risk of seeking illicit alternative opioid sources.

To protect patients from the risks of rapid tapering, providers should opt for a slow tapering process in an office setting:

- If withdrawal symptoms are significant, providers may prescribe medication to ease symptoms.
- Providers may implement (or increase usage of) nonopioid pain management strategies, including CBT, PT, nonopioid analgesics, and tools to manage insomnia, anxiety, or depression.

Patient Education

Patient education is critical for informed consent and shared decision making. Informed consent is particularly important when providers are prescribing potentially addictive medications for patients who have a history of SUDs. Providers need to acknowledge that the patient using opioid therapy is potentially jeopardizing recovery and functioning by undertaking pain treatment.

Patients who have been opioid abstinent may not realize that they have a reduced tolerance and are at higher risk of overdose. They should be educated about such risk and provided naloxone prescriptions. Having a naloxone kit on hand is a good precaution for anyone who is taking opioids. Five states—Arizona, Florida, Rhode Island, Vermont, and Virginia—now mandate coprescription of naloxone. A growing number of states have added naloxone to Medicaid formularies or mandated that insurers cover its cost (Green et al., 2020).

To enhance open and honest communication with a diverse patient population, use the following strategies (examples of each of these strategies can be found in TIP 54, pp. 66–68):

- Tailor education to each patient's individual needs and cultural identity
- Use simple language
- Supplement with visuals
- Ask open-ended questions to promote dialog
- Ask patients to explain or demonstrate the provider's instructions to be sure the patient understands clearly (teach-back method)

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Resources

- **Substance Abuse and Mental Health Services Administration (SAMHSA)**
  - *Rx Pain Medications: Know the Options, Get the Facts*
  - TIP 54, *Managing Chronic Pain in Adults With or in Recovery From Substance Use Disorders*
- **American Academy of Pain Management, Opioid Agreements & Contracts**
- **Centers for Disease Control and Prevention (CDC)**
  - *Checklist for Prescribing Opioids for Chronic Pain*
  - *CDC Guideline for Prescribing Opioids for Chronic Pain—United States, 2016*
- ***HHS Guide for Clinicians on the Appropriate Dosage Reduction or Discontinuation of Long-Term Opioid Analgesics***
- **National Institute on Drug Abuse (NIDA)**
  - Resource Guide: Screening for Drug Use in General Medical Settings
- **Oregon Pain Guidance**
  - *Opioid Prescribing Guidelines*

Bibliography

American Society of Addiction Medicine. (2020). *The ASAM national practice guideline for the treatment of opioid use disorder—2020 focused update.* www.asam.org/docs/default-source/quality-science/npg-jam-supplement.pdf?sfvrsn=a00a52c2_2

Archer, K. R., Devin, C. J., Vanston, S. W., Koyama, T., Phillips, S. E., George, S. Z., … Wegener, S. T. (2016). Cognitive-behavioral–based physical therapy for patients with chronic pain undergoing lumbar spine surgery: A randomized controlled trial. *Journal of Pain, 17*(1), 76–89.

CADTH Rapid Response Reports. (2016). *Physical therapy treatments for chronic non-cancer pain: A review of guidelines.* www.cadth.ca/sites/default/files/pdf/htis/2016/RC0822%20Physical%20Therapy%20for%20Chronic%20Pain%20Final.pdf

Centers for Disease Control and Prevention. (2020). *Checklist for prescribing opioids for chronic pain.* U.S. Department of Health and Human Services. www.cdc.gov/drugoverdose/pdf/pdo_checklist-a.pdf

Chang, Y.-P., & Compton, P. (2013). Management of chronic pain with chronic opioid therapy in patients with substance use disorder. *Addiction Science and Clinical Practice, 8,* 21.

Colloca, L., Ludman, T., Bouhassira, D., Baron, R., Dickenson, A. H., Yamitsky, D., … Raja, S. N. (2017). Neuropathic pain. *Nature Reviews Disease Primers, 3,* 17002.

Courtney, C. A., Fernandez-de-Las-Penas, C., & Bond, S. (2017). Mechanisms of chronic pain: Key considerations for appropriate physical therapy management. *Journal of Manual and Manipulative Therapy, 25*(3), 118–127.

Dahlhamer, J., Lucas, J., Zelaya, C., Nahin, R., Mackey, S., DeBar, L., … Helmick, C. (2018). Prevalence of chronic pain and high-impact chronic pain among adults—United States, 2016. *Morbidity and Mortality Weekly Report, 67*(36), 1001–1006.

Derry, S., Conaghan, P., Da Silva, J. P., Wiffen, P. J., & Moore, R. (2016). Topical NSAIDs for chronic musculoskeletal pain in adults. *Cochrane Database of Systematic Reviews, 4,* CD007400.

do Nascimento, D. Z., Marques, G. M., & Schuelter-Trevisol, F. (2020). Potential psychotropic drug interactions among drug-dependent people. *Journal of Psychoactive Drugs,* November 22, 1–9. https://riuni.unisul.br/bitstream/handle/12345/10651/ArtigoDiego.pdf?sequence=1&isAllowed=y

Dowell, D., Haegerich, T. M., & Chou, R. (2016). CDC guideline for prescribing opioids for chronic pain—United States, 2016. *MMWR Recommendations and Reports, 65*(RR-1), 1–49.

Food and Drug Administration. (2020). New recommendations for naloxone. www.fda.gov/drugs/drug-safety-and-availability/new-recommendations-naloxone

Furlan, A. D., Giraldo, M., Baskwill, A., Irvin, E., & Imamura, M. (2015). Massage for low-back pain. *Cochrane Database of Systematic Reviews, 1*(9), CD001929.

Green, T. C., Davis, C., Xuan, Z., Walley, A. Y., & Bratberg, J. (2020). Laws mandating coprescription of naloxone and their impact on naloxone prescription in five US states, 2014–2018. *American Journal of Public Health, 110*(6), 881–887.

Hajihasani, A., Rouhani, M., Salavati, M., Hedayati, R., & Kahlaee, A. H. (2019). The influence of cognitive behavioral therapy on pain, quality of life, and depression in patients receiving physical therapy for chronic low back pain: A systematic review. *PM&R, 11*(2), 167–176.

Himstreet, J., Popish, S. J., Wells, D. L., & Lau, M. (2017). *Acute pain management: Meeting the challenges. A VA clinician's guide.* U.S. Department of Veterans Affairs. www.pbm.va.gov/PBM/AcademicDetailingService/Documents/Academic_Detailing_Educational_Material_Catalog/Pain_Provider_AcutePainProviderEducationalGuide_IB10998.pdf

Kroenke, K., & Spitzer, R. L. (2002). The PHQ-9: A new depression diagnostic and severity measure. *Psychiatric Annals, 32,* 509–521.

Kroenke, K., Spitzer, R. L., & Williams, J. B. (2001). The PHQ-9: Validity of a brief depression severity measure. *Journal of General Internal Medicine, 16*(9), 606–613.

Malfliet, A., Bilterys, T., Van Looveren, E., Meeus, M., Danneels, L., Ickmans, K., … Nijs, J. (2019). The added value of cognitive behavioral therapy for insomnia to current best evidence physical therapy for chronic spinal pain: Protocol of a randomized controlled clinical trial. *Brazilian Journal of Physical Therapy, 23*(1), 62–70.

National Center for Complementary and Integrative Health. (2020). Acupuncture: In depth. www.nccih.nih.gov/health/acupuncture-in-depth

National Library of Medicine. (2020). Label: Vivitrol—naltrexone kit. https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=cd11c435-b0f0-4bb9-ae78-60f101f3703f

Richardson, T. M., He, H., Podgorski, C., Tu, X., & Conwell, Y. (2010). Screening for depression in aging services clients. *American Journal of Geriatric Psychiatry, 18*(12), 1116–1123.

Saha, F. J., Schumann, S., Cramer, H., Hohmann, C., Choi, K.-E., Rolke, R., … Lauche, R. (2017). The effects of cupping massage in patient with chronic neck pain: A randomized controlled trial. *Complementary Medicine Research, 24*(1), 26–32.

Saper, R. B., Lemaster, C., Delitto, A., Sherman, K. J., Herman, P. M., Sadikova, E., … Weinberg, J. (2017). Yoga, physical therapy, or education for chronic low back pain: A randomized noninferiority trial. *Annals of Internal Medicine, 167*(2), 85–94.

Thompson, D. P., Oldham, J. A., & Woby, S. R. (2016). Does adding cognitive-behavioural physiotherapy to exercise improve outcome in patients with chronic neck pain? A randomised controlled trial. *Physiotherapy, 102*(2), 170–177.

U.S. Department of Health and Human Services Working Group. (2019). *HHS guide for clinicians on the appropriate dosage reduction or discontinuation of long-term opioid analgesics.* U.S. Department of Health and Human Services.

Zhang, Q., Jiang, S., Young, L., & Li, F. (2019). The effectiveness of group-based physiotherapy-led behavioral psychological interventions on adults with chronic low back pain: A systematic review and meta-analysis. *American Journal of Physical Medicine and Rehabilitation, 98*(3), 215–225.

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